Otolaryngologists' Role in Redeployment During the COVID-19 Pandemic: A Commentary

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Abstract

As otolaryngologists, we identify as subspecialists and fellowship-trained surgeons and may even identify as "super-subspecialists." The likelihood of being redeployed and drawing from knowledge learned during our postgraduate year 1 training seemed exceedingly unlikely until physician resources became scarce in some health care systems during the COVID-19 pandemic. More now than ever, it is evident that our broad training is valuable in helping patients and allowing the otolaryngologist to meaningfully contribute to the larger health care community, especially while the majority (70%-95%) of elective care is delayed. With our skill set, otolaryngologists are poised to support various aspects of hospital wards, intensive care units, emergency departments, and beyond.

Keywords COVID-19, otolaryngology, ENT, redeployment

Over the last several weeks of the COVID-19 pandemic, physicians across all practice settings volunteered or were required to redeploy to areas in need, such as emergency departments (EDs), hospital wards, intensive care units (ICUs), and virtual hubs. Initially, many believed that only a dire situation would necessitate the mobilization of otolaryngologists, since the first waves of redeployed physicians included internists, infectious disease physicians, pulmonologists, cardiologists, and family practitioners. However, many in the otolaryngology community were called to serve outside of their normal practice.

This is the author's manuscript of the article published in final edited form as:
Shipchandler, T. Z., Nesemeier, B. R., Schmalbach, C. E., & Ting, J. Y. (2020). Otolaryngologists' role in redeployment during the COVID-19 pandemic: a commentary. Otolaryngology–Head and Neck Surgery, 163(1), 94-95. https://doi.org/10.1177/0194599820926982

Although many otolaryngologists completed a dedicated general surgical internship, it is difficult to imagine that the skills, knowledge, and experiences learned during that time would be called on decades later. Working outside of one's comfort zone during the COVID-19 pandemic may provoke understandable anxiety. The otolaryngology community prides itself on delving deeper and learning more about various aspects of its field through research, patient experience, and surgical innovation. With an incredible depth of knowledge from the skull base to the clavicles, many otolaryngologists appropriately deferred the broader scope of medical management to preoperative outpatient clinics, primary care providers, hospitalists, and consulting services.

Despite the highly specialized medical expertise and associated elective case load, otolaryngologists fulfill helpful and often necessary roles beyond their field during the COVID-19 pandemic. Many otolaryngologists found themselves more "available" for redeployment as compared with other health care providers due to the cancellation of elective surgery, decline in referrals, and transition to telehealth visits.

Some overburdened health systems needed physicians to fill gaps for emergency physicians, hospitalists, or intensivists who were quarantined, overworked, or otherwise unavailable.1 Though we as otolaryngologists cannot fully replace any of these physicians, our skill set enables us to help in many of those settings.

It is estimated that 2.21% of ED visits are otolaryngology related.2 Redeployment to the emergency room therefore may be a natural transition. For EDs overwhelmed with patients with COVID-19, a surgical pod annex staffed by the otolaryngologist is an additional way to streamline and offload the ED demands. Epistaxis, peritonsillar abscess, and facial trauma are common ED visits. Oftentimes the examination and intervention necessitate high-risk aerosol-generating procedures (AGPs). Examination of these patients by a trained otolaryngologist limits unnecessary exposure of other ED personnel. Additional benefits of this streamlined specialty approach include reduction of personnel required for the procedure, minimal use of the coveted personal protective equipment, and potentially diminished aerosolization of the virus. Furthermore, EDs benefit from having an airway expert available when the

otolaryngologist is working a shift. Notable benefits are shorter time to intubation, streamlined surgical airway management, and minimal time spent performing otolaryngologic-associated AGPs.

Though an otolaryngologist may not be able to provide independent comprehensive care for patients in the ICU or inpatient setting, we serve useful roles within a pyramid team structure managed by a critical care physician. During our internships and residency, otolaryngologists spent countless hours rounding on surgical wards and ICUs. In addition, many otolaryngologists continue to provide call coverage to local small or large metropolitan hospitals, including inpatient consulting services. By providing care in familiar inpatient settings to patients with lower acuity and assisting with procedures such as airway management, otolaryngologists provide much-needed support to our critical care and hospitalist colleagues as they deal with an influx of patients who are COVID-19 positive and unstable.

Ultimately, areas of redeployment for the otolaryngologist will vary by individual institution and practice needs, as well as the stage along the pandemic curve. By nature of a pandemic, areas of need are moving targets that will change, sometimes on a weekly basis. Additional examples for redeployment include testing stations where the otolaryngologist can easily swab the nasopharynx. With increasing employee exposures, occupational health services had to expand. If given appropriate education to include a script and algorithm, the otolaryngologist can readily fill this role. Depending on resources, otolaryngologists may even find themselves supporting the health system through nonmedical jobs to include transport and environmental services.

Last, redeployment provides the opportunity to serve the community while maintaining some financial stability. During the COVID-19 pandemic, most otolaryngologists have experienced a 70% to 90% reduction in surgical volumes, especially in states where government decree placed a hold on elective procedures and a delay in semiurgent procedures.3 Outpatient otolaryngology visits, even with a robust telehealth program, created obstacles: technology shortcomings on the patient side, costs on the provider side, HIPAA compliance issues (Health Insurance Portability and Accountability Act), and most of all, inability to perform necessary physical examinations or office-based nasal endoscopy and laryngoscopy.4 In-office AGPs for

semiurgent cases were further limited by the relative shortage of personal protective equipment.5 An abundance of COVID-19 residing in the upper aerodigestive tract increases the risk of many otolaryngologic procedures.6-8 With some exceptions, such as aggressive head and neck malignancy, most otolaryngology operations can be deferred until resources and safety protocols are established. This decreased volume carries significant negative economic impact and financial strain to many physician practices. Redeployment to other roles provides the ability to offset some of this lost revenue for the health system and ultimately the provider.

Conclusion

Redeployment of otolaryngologists, whether by choice or necessity, occurred during the COVID-19 pandemic. As productive, adaptable members of the wider medical community, we must embrace our skill sets and broader medical knowledge. Doing so provides opportunities to help the larger health care community while potentially alleviating the financial strain for one's practice and those around us.

Author Contributions

Taha Z. Shipchandler, manuscript drafting, editing, final sign-off; B. Ryan Nesemeier, manuscript drafting, editing, final sign-off; Cecelia E. Schmalbach, manuscript drafting, editing, final sign-off; Jonathan Y. Ting, manuscript drafting, editing, final sign-off.

Disclosures

Competing interests: None.

Sponsorships: None.

Funding source: None.

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